MDR Tracking Number: M5-03-0501-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-18-02.

The IRO reviewed work hardening rendered from 10-29-01 through 11-16-01 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for work hardening. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-20-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. Documentation was not submitted in accordance with Rule 133.307(l) to confirm services were rendered for dates of service 10-19-01 through 10-23-01, 10-29-01,10-30-01, 10-31-01,11-01-01, 11-02-01, 11-05-01, through 11-09-01, and 11-12-01 through 11-16-01. Therefore reimbursement is not recommended.

This Decision is hereby issued this 3rd day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at

the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for work hardening for dates of service 10-29-01 through 11-16-01 in this dispute.

This Order is hereby issued this 3rd day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter**
Note: Decision

June 25, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-0501-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient was injured on ___ from repetitive trauma to her right wrist and forearm. Her job entails continuous data entry and she developed pain and weakness. An electromyography from 02/08/01 revealed moderate to severe carpal tunnel syndrome on

the right. She underwent a carpal tunnel release on 06/13/01 and began post-operative therapy when released by her surgeon.

Requested Service(s)
Work hardening program from 10/29/01 through 11/16/01

Decision
It is determined that the work hardening program from 10/29/01 through 11/16/01 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision
An aggressive post surgical rehabilitation program was completed. The patient then was progressed into the tertiary level of care of work hardening. This program was completed and the patient was placed on maximum medical improvement (MMI) on 11/21/01 with an 8% impairment rating. Each visit and service was properly documented with subjective symptoms, objective findings, assessment and plan thereby demonstrating the medical necessity.

National treatment guidelines as well as TWCC treatment guidelines clearly allow for treatment to progress from the secondary phase of treatment into the tertiary phase of treatment as was the case with this patient. Therefore, it is determined that the work hardening program from 10/29/01 through 11/16/01 was medically necessary.

Sincerely,